Alder Hey Children's NHS
NHS Foundation Trust

National Clinical Assessment Team (NCAT) Review

Proposals for changes to the provision of healthcare services for children and young people in Brent and Harrow.

Report by Dr. Steve Ryan, Medical Director, Alder Hey Children's NHS Foundation Trust Liverpool.

Report To

SRO
Chief Executives of NHS Brent, NHS Harrow, North West London Hospitals Trust

Date of NCAT Review 8th December 2009

Evidence used as basis of review

a) Preconsultation Business Case; Healthcare Services for Children and Young People in Brent and Harrow Draft (Version 1.2).

b) Draft report on the preconsultation campaign for the Acute Services Review of Children's Services in Brent and Harrow 16th November 2009.

c) Report on reconfiguration of children's services across Brent and Harrow to Children's Partnership Board 5th November 2009.

d) Paediatric reconfiguration – interviewee's brief prepared by Dr. Paul Mannix, Clinical Director and David Cheesman, Director of Strategy, NWLHT.

e) Data on length of stay at both paediatric units (Central Middlesex Hospital – CMH and NWLHT). Upto date statistics on length of stay.

f) Interviews held with Stakeholders at Northwick Park on 8th December 2009 (Appendix 1).

OUTLINE OF PROPOSAL

In essence this proposal is centred on improving the quality and appropriateness of care for Children and Young People in Brent & Harrow, through changes to the

model of care from community through primary and secondary care pathways and should be seen in that context. The key proposal at the centre of this reconfiguration is the transfer of all overnight inpatient care from two hospital sites to a single site at Northwick Park Hospital, but at the same time enhancing the provision of extended hours, consultant – run and led services for children in Brent & Harrow. If conducted as planned and if part of the "bigger picture" then I believe it will deliver the improvements needed in the quality and appropriateness of care.

KEY DRIVERS AND RESPONSE TO THEM

a) The existence of a six bedded inpatient unit supported by a separate on-call system, with an average length of stay of below 1 day, almost in itself makes a case for reconfiguration. It is clear that this situation is in part due to the relatively low dependency casemix of children admitted to CMH but also a testament to the evolving ambulatory model of care at that hospital. The average length of stay at Northwick Park is even shorter and given that more specialised care is delivered to some groups of patients, suggests that there are a large number of patients who could benefit from an ambulatory approach, such as delivered in Paediatric assessment unit on both sites. I believe that the establishment of effective Paediatric Assessment Units will, with the flexible capacity at Northwick Park, ensure that there is an adequate number of beds for children and young people who require them.

b) A clear driver for use of hospital acute services through Accident and Emergency, particular at the Central Middlesex Site is self-referral. The local population clearly see this as their first port of call for unplanned care needs significant improvement, rather than primary care provision. This is a national problem and a London problem, but seems as significant as anywhere in Harrow and Brent. At interview not one person disagreed that 50-70% of children were accessing hospital services inappropriately. Clearly the model of care needs to change, so that the paediatric services can focus on the care that they need to deliver. My understanding is that an unplanned care centre (Primary Care delivered) will be established on the Central Middlesex Site. This is an important key step which will free up the paediatric team to further develop the quality of care they should appropriately deliver. My understanding is that capability and parental confidence in primary care for children presenting with unplanned care needs significant improvement. There's a real opportunity to use the Paediatric Team in the future to support the building and maintenance of these improvements. This would also help towards developing a more integrated delivery model. Communication to users is quite rightly seen as a key enabler to success, but will be challenging given

the culture, language, literacy and deprivation issues that are prevalent in the population served.

KEY ISSUES TO ADDRESS WITHIN THE PROPOSAL

a) Waiting times and hand-offs should be reduced to a minimum in the interactions between A&E, urgent care centres and paediatric assessment unit and the inpatient service.

b) Sickle cell patients need confidence in the inpatient service proposed at Northwick Park.

c) Clarity is needed on the right terminology of describing the use of consultants at the front line. Using them to be the first receiver for the large "primary care" workload is not consistent with effective and efficient practice.

d) The transport system for children moving from Central Middlesex to Northwick Park needs to be of the correct level for quality and safety. Further consideration needs to be given to 'transport back' and transport of families to Northwick Park.

e) There needs to be confidence that there will be sufficient capacity for inpatients in the future (enough beds).

f) The potential reduction in tariff based income for the Trust may significantly outweigh cost reductions that are possible.

g) Access to the inpatient beds at Northwick Park needs to be equitably accessible across the patch.

h) There is a need for standardisation and harmonisation of Clinical Pathways for community and unplanned care pathways across the Brent and Harrow and Hospital footprint.

i) There is a need to get clinical adjacencies right for children on both sites (inpatient, paediatric assessment, accident and emergency, unplanned care centre).

j) Different models of community nursing and safeguarding activity and access to therapists where outlined across the two PCT areas and hospital sites.

k) The uncertainty caused by the delay in agreeing moving to a solution has had an effect on nurse requirement.

THE BENEFITS OF PATIENTS RECEIVING ALL INPATIENT CARE AT THE NORTHWICK PARK SITE.

- Improved access to a range of medical expertise specialties, urgent anaesthesia intensive care, neonatal care, out of hours surgery, 2 senior paediatric residents; increasing resilience.
- Improved access to a range of therapy services
- More cost effective use of resources
- Allows investment in care closer to home

THE BENEFITS OF PAEDIATRIC ASSESSMENT UNITS ON BOTH SITES

- Builds on current ambulatory provision
- Consultants at the frontline – they get to see the right patients quickly
- Will avoid some overnight stays

CONCLUSIONS AND RECOMMEDNATIONS

This is a sound proposal and well considered and had the support of all parties interviewed. It is focussed on patients and quality of services and it is appropriate that the options outlined and the preferred option go forward to formal public consultation. The proposal is coherent with national guidance, regional frameworks and local strategy. It is not a blind alley, and allows further improvement in the future and the opportunity for vertical and horizontal integration. The proposals are clinically owned and clinically led. The preconsultation engagement is impressive. The quality of clinical engagement, leadership and passion for care shown by those interviewed was outstanding and a great foundation for future progress. In terms of key issues to consider, I attach a table to summarise my recommendations.

I would like to thank all those involved in the process but most particularly Delia Mills and David Cheesman for their care in preparing for review.

Steve Ryan
MEDICAL DIRECTOR
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

ISSUE	RECOMMENDATION
Waiting times and hand-offs should be reduced to a minimum in the interactions between A&E, urgent care centres and paediatric assessment unit and the inpatient service.	Develop clear protocols for transfers between the elements, or signposting. Develop a system for monitoring waits along the whole pathway. Consider moving management of A&E for children at Northwick Park to the Paediatric Team.
Sickle cell patients need confidence in the inpatient service proposed at Northwick Park.	Ensure very specific consultation with this group, building on excellent work so far. Engage young people in designing the service (systems, processes, and look and feel of facility). Engage young people in training staff at Northwick Park.
Clarity on using the right terminology of using consultants at the front line using them to be the first receiver for the large "primary care" workload is not consistent with effective and efficient practice.	Clearly define what consultants – at – the front line means.
The transport system for children moving from Central Middlesex to Northwick Park needs to be of the correct level for quality and safety. Consideration needs to be given to 'transport back' and transport of families to Northwick Park.	Ensure that ambulance transport system meets acceptable standards for safe and effective transfer of sick children. A highbrid model may be required. Describe service for transfer back home.
There needs to be confidence that there will be sufficient capacity for inpatients in the future (enough beds).	Current proposals should address this issue.
The potential reduction in tariff based income for the Trust may significantly outweigh cost reductions that are possible.	The business decisions related to this change should result in a 'win' for the patients, a 'win' for the hospital Trust and a 'win' for the PCT. Appropriate levers should operate to allow this risk sharing to support vertical integration.
The need for access to the inpatient beds at Northwick Park to be equitably accessible.	Current proposals should address this issue.
The need for standardisation and harmonisation of Clinical Pathways for community and unplanned care pathways	A top ten approach to key pathways is suggested. This will be a helpful focus for clinicians. Suggested

across the Brent and Harrow and Hospital footprint.	pathways include Asthma, Diarrhoea and vomiting, sickle cell disease, the child with fever.
The need to get clinical adjacencies right for children on both sites (inpatient, paediatric assessment, accident and emergency, unplanned care centre).	Clinical adjacencies should be considered as part of estates strategies.
Different models of community nursing and safeguarding activity and access to therapists where outlined across the two PCT areas and hospital sites.	To consider developing unified models of community nursing, safeguarding provision, access to therapists that operate across both PCTs and hospital sites, that maximise equitable, needs-based access and deliver cost effectiveness and quality.
The uncertainty caused by the delay in agreeing moving to a solution has had an effect on nurse requirement.	To further consider how nursing teams are supported through this proposed change to ensure a high quality workforce is received and retained.